

PERSONAL HISTORY

Name _____ Date _____

Home Address _____ City _____ Zip _____

Home Phone _____ Birthdate _____

Cell Phone _____ Email _____

Social Security No. _____ Martial Status _____

Employer _____ Occupation _____

Bus. Address _____ City _____ Zip _____

Bus. Phone _____

Spouse's Name _____ Spouse's Employer _____

Bus. Address _____ City _____ Zip _____

Bus. Phone _____

Who should we call in an emergency? _____ Phone _____

Person responsible for Account _____

How did you hear about our office? _____

Are you covered by a Dental Insurance plan? Yes ___ No ___

If yes, Name of Company _____ I.D. No. _____

Primary insurance carriers name _____ Birthday _____

DENTAL INFORMATION

1. Reason for visit: _____

2. Date of last treatment: _____

3. Date of last teeth cleaning: _____

4. How often do you brush? _____

5. How often do you floss? _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	6. Do you supplement your diet with fluoride?
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you having pain at this time?
		8. Have you had:
<input type="checkbox"/>	<input type="checkbox"/>	a. orthodontic treatment (braces)?
<input type="checkbox"/>	<input type="checkbox"/>	b. oral surgery?
<input type="checkbox"/>	<input type="checkbox"/>	c. gum treatment?
<input type="checkbox"/>	<input type="checkbox"/>	d. your teeth ground or the bite adjusted?
<input type="checkbox"/>	<input type="checkbox"/>	e. or worn a bite plane or other appliance?
<input type="checkbox"/>	<input type="checkbox"/>	9. Have you noticed any loosening of your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	10. Does food tend to become caught between your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	11. Do your gums often bleed when you brush your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have any sores or lumps in or near your mouth?
<input type="checkbox"/>	<input type="checkbox"/>	13. Are you dissatisfied with the function of your teeth?
		14. Problems of the jaw. Have you ever experienced:
<input type="checkbox"/>	<input type="checkbox"/>	a. clicking of the jaw?
<input type="checkbox"/>	<input type="checkbox"/>	b. pain (joint, ear, side of face)?
<input type="checkbox"/>	<input type="checkbox"/>	c. difficulty in opening and closing?
<input type="checkbox"/>	<input type="checkbox"/>	d. difficulty in chewing?



Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	15. Have you had any head, neck, or jaw injuries?
		16. Habits. Do you:
<input type="checkbox"/>	<input type="checkbox"/>	a. clench or grind your teeth while awake or asleep?
<input type="checkbox"/>	<input type="checkbox"/>	b. bite your lips or cheeks frequently?
<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever had an upsetting experience in the dental office?
<input type="checkbox"/>	<input type="checkbox"/>	18. Is it important to you to keep your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	19. Are you dissatisfied with the appearance of your smile?
<input type="checkbox"/>	<input type="checkbox"/>	20. Is there anything about having dental treatment that bothers you?
		21. Previous dentist _____

If yes to any of the above, please explain:

MEDICAL INFORMATION

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has there been any change in your general health within the past year?
<input type="checkbox"/>	<input type="checkbox"/>	2. Your last physical examination was on: _____
<input type="checkbox"/>	<input type="checkbox"/>	3. Are you now under care of a physician?
<input type="checkbox"/>	<input type="checkbox"/>	4. Name, address, and phone no. of physician is: _____

<input type="checkbox"/>	<input type="checkbox"/>	5. Have you been hospitalized for any surgical operation or serious illness?
<input type="checkbox"/>	<input type="checkbox"/>	6. Do you have or have you had any of the following diseases or problems:
<input type="checkbox"/>	<input type="checkbox"/>	a. rheumatic fever, scarlet fever, or rheumatic heart diseases?
<input type="checkbox"/>	<input type="checkbox"/>	b. heart defect or heart murmur?
<input type="checkbox"/>	<input type="checkbox"/>	c. heart trouble, heart attack, or angina?
<input type="checkbox"/>	<input type="checkbox"/>	(1) do you have pain in your chest upon exertion?
<input type="checkbox"/>	<input type="checkbox"/>	(2) are you ever short of breath after mild exercise?
<input type="checkbox"/>	<input type="checkbox"/>	(3) do your ankles swell?
<input type="checkbox"/>	<input type="checkbox"/>	(4) do you get short of breath when you lie down, or do you require extra pillows when you sleep?
<input type="checkbox"/>	<input type="checkbox"/>	(5) artificial heart valve
<input type="checkbox"/>	<input type="checkbox"/>	(6) mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	d. pacemaker?
<input type="checkbox"/>	<input type="checkbox"/>	e. heart surgery?

- | Yes | No | |
|--------------------------|--------------------------|--|
| 6. Continued | | |
| <input type="checkbox"/> | <input type="checkbox"/> | f. high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | g. stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | h. hepatitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | i. sinus trouble? |
| <input type="checkbox"/> | <input type="checkbox"/> | j. lung or breathing problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | k. asthma or hay fever? |
| <input type="checkbox"/> | <input type="checkbox"/> | l. hives or skin rash? |
| <input type="checkbox"/> | <input type="checkbox"/> | m. fainting spells or seizures? |
| <input type="checkbox"/> | <input type="checkbox"/> | n. diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | (1) do you have to urinate more than 6 times a day? |
| <input type="checkbox"/> | <input type="checkbox"/> | (2) are you thirsty much of the time? |
| <input type="checkbox"/> | <input type="checkbox"/> | (3) does your mouth often become dry? |
| <input type="checkbox"/> | <input type="checkbox"/> | o. allergies? |
| <input type="checkbox"/> | <input type="checkbox"/> | p. liver disease or jaundice? |
| <input type="checkbox"/> | <input type="checkbox"/> | q. thyroid problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | r. arthritis, rheumatism? |
| <input type="checkbox"/> | <input type="checkbox"/> | s. joint replacement or implant? |
| <input type="checkbox"/> | <input type="checkbox"/> | t. stomach ulcers? |
| <input type="checkbox"/> | <input type="checkbox"/> | u. kidney trouble, kidney transplant or dialysis? |
| <input type="checkbox"/> | <input type="checkbox"/> | v. tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | (1) do you have a persistent cough or cough up blood? |
| <input type="checkbox"/> | <input type="checkbox"/> | w. low blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | x. do you use tobacco? |
| <input type="checkbox"/> | <input type="checkbox"/> | y. chemical dependency (drugs, alcohol)? |
| <input type="checkbox"/> | <input type="checkbox"/> | z. venereal disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you had abnormal bleeding associated with previous tooth extractions, surgery, or injuries? |
| <input type="checkbox"/> | <input type="checkbox"/> | a. do you bruise easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. have you ever required a blood transfusion? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have any blood disorders such as anemia or leukemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you have any eye problems such as glaucoma? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had surgery or X-ray treatment for a tumor, growth, or other condition of your mouth or lips? |

- | Yes | No | |
|---|--------------------------|---|
| 11. Are you taking any of the following: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. antibiotics or sulfa drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. anticoagulants (blood thinners)? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. medicine for high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. cortisone (steroids)? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. tranquilizers? |
| <input type="checkbox"/> | <input type="checkbox"/> | f. dilantin? |
| <input type="checkbox"/> | <input type="checkbox"/> | g. antihistamines? |
| <input type="checkbox"/> | <input type="checkbox"/> | h. aspirin? |
| <input type="checkbox"/> | <input type="checkbox"/> | i. insulin, tolbutamide (orinase), or other drug to control blood sugar? |
| <input type="checkbox"/> | <input type="checkbox"/> | j. digitalis or drugs for heart trouble? |
| <input type="checkbox"/> | <input type="checkbox"/> | k. nitroglycerin? |
| <input type="checkbox"/> | <input type="checkbox"/> | l. oral contraceptives? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| 12. Are you allergic to or have you had reactions to: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. local anesthetic like novocaine? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. penicillin or other antibiotics? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. sulfa drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. barbiturates, sedatives, or sleeping pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. aspirin? |
| <input type="checkbox"/> | <input type="checkbox"/> | f. iodine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any trouble associated with a previous dental treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Does anyone in your family have any disability, birth defects, or growth related problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Herpes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you have any disease, condition, or problem not listed above that you think I should know about? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you had an Aids/HIV test? <input type="checkbox"/> positive <input type="checkbox"/> negative |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Women: |
| <input type="checkbox"/> | <input type="checkbox"/> | a. are you pregnant or think you might be pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. are you nursing presently? |

If yes to any of the above, please explain:

Signature _____ (Patient or parent/guardian if patient is under age 18) Date _____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Authorized Signature of Covered Person/Employee _____ Date _____